Complete the Ohio Medicaid Individual Practitioner Application/Agreement, attach required documentation, and mail to:

Provider Relations Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, Ohio 43266-0161

Should you have any questions regarding completion of your application/agreement form, call our Provider Enrollment Unit at 1-800-686-6108, OPTION 2. Out of state call (614) 728-3288, OPTION 2.

Submit completed signed application/agreement with attachments to:
Provider Relations Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43266-0161

(For State Use Only)

ODHS 6750 (Rev 6/97)

Medicaid Provider Enrollment Application/Agreement for Individual Practitioners

Complete all applicable items if you plan to bill Medicaid as an individual physician or non-physician practitioner. All physicians and non-physician practitioners who are members of a group must apply as individuals for Medicaid enrollment.

Individual Provider Types: (Mark only ONE box to indicate your Provider Type).

- ☐ Chiro/Mechano (37)
- ☐ Chiropractor (27)
- ☐ Clinical Nurse Specialist (65)
- ☐ Dentist (30)
- ☐ Independent Home Care Nurse (38)
- ☐ Nurse, Anesthetist (73)
- ☐ Nurse, Midwife (71)
- ☐ Nurse, Practitioner (72)
- ☐ Optician (75)
- ☐ Optometrist (35)
- ☐ Osteopath (22)
- ☐ Physical Therapist (39)
- ☐ Physician (20)
- ☐ Podiatrist (36)
- ☐ Psychologist (42)
- ☐ Waiver IDL Aide (17)
- ☐ Waiver IDL Non-Aide (18)
- ☐ Waiver Service Provider (45)

Provider Identification: (Print or type entries)

Name (First)	(Middle Initial)	(Last)	Title (M.D., D.O., etc.)

Social Security Number (ALL Individual Practitioners)		Employer Identification Number (Incorporated Individuals, only)
___ ___ ___ - ___ ___ - ___ ___ ___ ___	You must attach a signed W-9 form With individual's name, address, social security number, original signature, and date. Do not use GROUP tax ID number.	___ ___ - ___ ___ ___ ___ ___ ___ ___

DEA number
___ ___ ___ ___ ___ ___ ___ ___ ___
* You must attach copy of Certificate

Address Information: (Print or type entries)

Physical Location of Practice/Business (Applicants: If more than one location, list Primary.)

Building Name / or / Department / or / In care of			
Practice Address (Number Street Avenue Route, etc. P O Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4 if possible)
Telephone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___			

"Pay to" Address (Name & Address to which Payment or Remittance Advice is to be mailed)

(If Address is not different from "Physical Location of Practice" address, leave blank)

Building Name / or / Department / or / In care of			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

If Address is not different from "Physical Location of Practice" address, leave blank)

Building Name / or / Department / or / In care of			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)

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(For State Use Only)

Caution | ALL blocks in the licensure section must be completed to avoid return of application/agreement

Licensure Information: (Print or type entries)

License number*	License Issuance Date (mm/dd/yyyy)	Current License Expiration Date* (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

*You must attach copy of State Board License

* You must attach copy of Renewal Card

Medicare Identification Information: (Print or type entries)

(If you are a participating Medicare provider: enter your Medicare information) Required for: Psychologist and Physical Therapist

PIN number (s) (Do not use UPIN)	CLIA number*	DMERC number*

* You must attach copy of CLIA Certificate

* You must attach copy of DMERC Certificate

Physician/Oral Surgeon Specialty Certification: (Complete only if Board Certified)

PRIMARY Specialty Type	Board Name	Certification Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
SECONDARY Specialty Type	Board Name	Certification Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Enter any Ohio Medicaid 7-digit Group Provider Numbers you are Affiliated with:

1 _ _ _ _ _ _ _ 2 _ _ _ _ _ _ _ 3 _ _ _ _ _ _ _ 4 _ _ _ _ _ _ _ 5 _ _ _ _ _ _ _

6 _ _ _ _ _ _ _ 7 _ _ _ _ _ _ _ 8 _ _ _ _ _ _ _ 9 _ _ _ _ _ _ _ 10 _ _ _ _ _ _ _

Nurse Applicants: (Print or type entries)

Are you an APN Pilot Program Participant? ☐ YES ☐ NO If Yes, do you have Prescriptive Authority? ☐ YES ☐ NO

Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

* You must attach copy of Certificate

* You must attach copy of Renewal Card

Do you have a Certificate of Authority? (NON PILOT PROGRAM PARTICIPANTS) ☐ YES ☐ NO

Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

* You must attach copy of Certificate

* You must attach copy of Renewal Card

Specialty Certification Number*	Certification Date (mm/dd/yyyy)	Current Renewal Date* (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

* You must attach copy of Certificate

* You must attach copy of Renewal Card

CRNA's (Only)

CRNA Certificate Number*	CRNA Recertification Date (mm/dd/yyyy)	CRNA Recertification Card Expiration Date (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

* You must attach copy of Certificate

* You must attach copy of Recertification Card

RN License number	License Issuance Date (mm/dd/yyyy)	Current License Expiration Date* (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

* You must attach copy of Renewal Card

Optional Category of Service: (If you will provide an Optional Category of Service mark your Provider Type, and mark the Categories of Service(s) you intend to provide.)

☐ Physician & Osteopath (20,22) ☐ 30-Prescribed Drugs, ☐ 32-Supplies and Medical Equipment,
☐ Nurse Practitioners (72) ☐ 30-Prescribed Drugs, ☐ 32-Supplies and Medical Equipment, ☐ 46-Waiver Services
☐ Dentist (30) ☐ 30-Prescribed Drugs, ☐ 43-Physician Services
☐ Optometrist (35) ☐ 30-Prescribed Drugs, ☐ 32-Supplies and Medical Equipment, ☐ 34-Eyeglasses

Remittance Advice:

I would like the claims listed on my Remittance Advice sorted by: check ONE only
☐ Recipient Name (1) ☐ Recipient ID (2) ☐ Transaction Control Number (3) ☐ Medical Control Number (4)

CD-ROM Capabilities:

Do you have CD-Rom capabilities? ☐ YES ☐ NO
Would you like to receive your handbooks and manuals on CD-ROM, as they become available? ☐ YES ☐ NO

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SUPERVISOR 7/1/99

Attachment 4.16-I

(For State Use Only)

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No"; marking the appropriate box; and/or giving the proper dates.

1. A. Have you or any individuals or organizations having a direct or indirect ownership or control interest in the professional association or practice been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ YES ☐ NO

Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
	__ __ / __ __ / __ __ __ __	
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
	__ __ / __ __ / __ __ __ __	

1. B. Have you or any of the employees of your professional association or practice ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ YES ☐ NO

Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
	__ __ / __ __ / __ __ __ __	
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
	__ __ / __ __ / __ __ __ __	

2. Type of Entity or Practice: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations
☐ Professional Corporation/Association ☐ Other (specify) _____

3. A. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)

☐ YES ☐ NO ATTACH EXPLANATION __ __ / __ __ / __ __ __ __

3. B. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)

☐ YES ☐ NO ATTACH EXPLANATION __ __ / __ __ / __ __ __ __

4. Is this entity or practice operated by a management company, or leased in whole or part by another organization? If yes, give date of change of operations. (mm/dd/yyyy)

☐ YES ☐ NO __ __ / __ __ / __ __ __ __

5. Have you or the entity or practice ever been sanctioned by the Medicare Program?
If "YES", when? (mm/dd/yyyy) How long? (mm/dd/yyyy)

☐ YES ☐ NO __ __ / __ __ / __ __ __ __ From __ __ / __ __ / __ __ __ __ to __ __ / __ __ / __ __ __ __

Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
	__ __ / __ __ / __ __ __ __	
Who was it? Give name(s)	When? Give date (mm/dd/yyyy)	SSN/EIN
	__ __ / __ __ / __ __ __ __	

6. Have you ever been issued an Ohio Medicaid 7-digit Provider Number?

☐ YES ☐ NO If, YES, you must list them in the boxes below.

7 digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number

7. Are there any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been convicted of a felony under State or Federal Law?

☐ YES ☐ NO

Who was it?	Type of offense?	When, give date? (mm/dd/yyyy)	SSN/EIN

TN No. 99-11 APPROVAL DATE DEC 14 1999

SUPERSEDES TN No. 98-11 EFFECTIVE DATE 7/1/99

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity or practice already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

(For State Use Only)

You must...

..complete Form W-9 with your **individual** name,address, social security number, original signature, and date, and attach it, do **not** use GROUP tax ID number,

..double check the **Application/Agreement** to make sure all applicable information has been included,

..complete the **State Board License** and **Renewal card** boxes correctly and attach the corresponding paperwork,

..look for footnotes (*) on the Application/Agreement and attach the necessary material,

..attach a copy of your **State Board License** and current **Renewal Card**,

..complete ALL date fields, especially licensure dates,

..sign and date the Application/Agreement at the bottom of page 5,

..complete the Medicare Indentification section with your **Provider Identification Number (PIN)**, not your Universal Provider Identifcation Number (UPIN)

..not remove any page from this Application/Agreement as to do so invalidates this Application/Agreement.

Failure to comply with any of the above **will** result in your application being returned and a delay in the approval process.

TN No. 99-009 APPROVAL DATE DEC 14 1999
SUPERSEDES
TN No. 98-11 EFFECTIVE DATE 7/1/99

Attachment 4.16-I

For State Use Only

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Human Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service;

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

   Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-173 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODHS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Human Servies, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

This provider agreement may be canceled by either party upon 30 days written notice prior to termination date except in the case of health maintenance organizations (HMOs) who must notify the Department in writing at least 90 days prior to the date of cancellation.

I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

For individual practitioners:

Individual Practitioner Name and Title (*please print*) : _____

Individual Practitioner Signature: _____ Date: _____ (mm/dd/yyyy)

TN No. 99-009 APPROVAL DATE 6/1/99

For groups or organizations:

Authorized Representative Name and Title (*please print*) : _____

SUPERSEDES

zed Representative Signature: _____ Date: _____ (mm/dd/yyyy)

TN No. 98-11 EFF DATE 7/1/99

ATTACH ALL COPIES OF LICENSURE, CERTIFICATION, REGISTRATION, ETC., AS REQUIRED FOR YOUR PROVIDER TYPE

APPLICATIONS SUBMITTED WITHOUT THE REQUIRED ATTACHMENTS WILL BE CONSIDERED INCOMPLETE AND RETURNED TO THE APPLICANT

For State Use Only

Signature of Authorized Agent: _____ *Date:* / /

(For State Use Only)

For State Use Only

Date Received(1)	Date Received(2)	Date Received(3)	Date Received(4)
Date Returned(1)	Date Returned(2)	Date Returned(3)	Date Returned(4)

Date Processed	Effective Date	Provider Number
Processed By	Application Number 11237	Ticket Number

This Form May NOT Be Duplicated

PN No. 99-009 APPROVAL DATE DEC 1

SUPERSEDES 98-11 7/1/99

DEPARTMENT OF MENTAL HEALTH/BOARD AGREEMENT TO PROVIDE COMMUNITY MENTAL HEALTH MEDICAL ASSISTANCE SERVICES

MEDICAID NUMBER MC ___ - ___

This Board Agreement is entered into by and between the Department of Mental Health ("ODMH") and _____ ("Board") for the provision and expansion of Community Mental Health ("CMH") Medicaid services to eligible individuals pursuant to Title XIX of the Social Security Act. This Agreement shall be effective the first day of July, 1999 and shall remain in effect until June 30, 2001 except that this Agreement may be extended for a period of two (2) years if agreed to by ODMH and the Board.

BOARD AGREEMENT TERMS

1. This ~~Board~~ Agreement is entered into pursuant to an Interagency Agreement between the Ohio Department of Human Services (ODHS), and the Ohio Department of Mental Health (ODMH). A copy of said Agreement is attached hereto as Exhibit A, and incorporated into this Agreement. A new Interagency Agreement between ODHS and ODMH and is pending, and upon completion, shall be incorporated into this Agreement and supersede Exhibit A as a new Exhibit A. In case of conflict between any provision of this Agreement and the new Exhibit A, the new Exhibit A shall be controlling.

2. Chapter 5101:3 – 27, "Community Mental Health Agency Services", of the Ohio Administrative Code is attached hereto as Exhibit J and is made a part of this Agreement. Any subsequent revisions to the Ohio Administrative Code applicable to services covered under this Agreement shall be incorporated into this Agreement as a new Exhibit J. In case of conflict between any provision of this Agreement and the new Exhibit J, the new Exhibit J shall be controlling.

3. The Board shall monitor services provided to its residents and process Medicaid claims for all residents of the Board's service district whether those services are provided by contract agencies within the county or in other counties. This will improve the ability of ADAMH Boards to evaluate quality and continuity of care and the cost effectiveness of services. The Board shall pay at 100%, valid Medicaid claims for Medicaid reimbursable services provided to residents of the Board's service district (as evidenced by the resident's assignment to the Board's group and plan) by any provider organization which has a Community Mental Health Medicaid Agreement with any ADAMHS Board. All provider organizations which currently have Community Health Medicaid Agreements are referenced in the document titled Enrolled Community Mental Health Medicaid Providers, which is incorporated into this Agreement as Exhibit I and which will be updated monthly. Because only Medicaid payments will be made pursuant to this paragraph, and because any payments made pursuant to this paragraph will be paid only to a provider organization which has a Community Mental Health Medicaid Agreement with an ADAMHS/CMH

Board and the terms of such Agreements are identical for all Boards, ODMH considers the requirements of ORC 340.03 (A) (6) (a) to be met for any Board making such payments to provider organizations. The Board which holds the Community Mental Health Medicaid Agreement with the provider organization is responsible for the performance of the Board Medicaid Compliance Review, follow-up on the A-133 and agreed upon procedures, audits, the review of budgets, and all other accountability requirements contained in the Community Mental Health Medicaid Agreement and all applicable State and Federal statutes, rules, and guidelines. In cases where a CMH agency serves residents of more than one (1) Board service district, the CMH agency may choose to have an Agreement with only one Board. In such cases, the CMH agency shall use the following criteria in making such decisions: 1. The Board in which the CMH agency is located, or 2. The Board with the greatest amount of projected CMH Medicaid expenditures. The CMH agency shall consult with each of the Boards which meet these criteria in making a determination about with which Board it will establish the Agreement. Nothing in this paragraph precludes a qualified CMH agency from seeking and being awarded a CMH Medicaid Agreement from any Board. Boards which makes payments pursuant to this paragraph shall follow up with the appropriate Board on issues related to service quality, cost-effectiveness, or continuity. The Board conducting the compliance review pursuant to Exhibit G of this Agreement shall ensure that services to residents outside of the service district are included in the review.

4. The Board shall adhere to the requirements of the "Guidelines and Operating Principles for Residency Determinations among CMH/ADAS/ADAMHS Boards". A copy of said "Guidelines" is attached hereto as Exhibit H. Please note this remains in draft form and will be finalized prior to July 1, 1999. Any revisions to Exhibit H shall be incorporated into this Agreement as a new Exhibit H. In case of conflict between any provision of this Agreement and the new Exhibit H, the new Exhibit H shall be controlling.

5. Any ODMH certified CMH agency may appeal an adverse determination by the Board and the Board assures that CMH agencies will not experience unnecessary delays in receiving decisions on Agreements from the Board. A CMH agency which has submitted all information to make a decision on an Agreement may appeal a delay as it would an adverse determination. The Board and CMH agency shall adhere to the appeal process and requirements set out below:

   a. The CMH agency may appeal the adverse determination by providing a written notice to the ODMH Deputy Director for Administrative Services that it wishes to appeal. The notice should be provided not earlier than ten (10) days and not later than sixty (60) days following an action by the Board to deny or terminate the Agreement. The Board may reconsider its action to terminate or deny the Agreement at any time prior to, or after the CMH agency submits a notice of appeal.

   b. ODMH must issue its determination on an appeal by a CMH agency not later than forty-five (45) days after receiving the appeal notice.

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c. ODMH review processes will include provisions for face-to-face meetings with the Board and the CMH agency when ODMH considers such a meeting necessary to conduct a thorough review.

d. If ODMH determines that an Agreement should be awarded or not terminated, the Board must award or continue the Agreement.

e. If ODMH affirms the denial or termination, it will forward the appeal to ODHS to hold an administrative hearing on the matter, if the CMH agency desires one.

6. The Board shall participate and cooperate in activities to identify instances of potentially inappropriate service utilization and in the performance of any corrective action necessary.

7. The Board hereby agrees to be subject to all requirements of all Exhibits attached hereto and/or referenced herein (and any amendments to said agreements), and all of these Exhibits and amendments thereto are made a part of this Agreement as if fully set forth herein.

8. The ODMH agrees to purchase and Board agrees to furnish, through participating CMH agencies, the medical assistance services covered under this Agreement provided on or after July 1, 1999. The services will be provided at the stated units of service, as set forth in Exhibit B.

9. The Board will be reimbursed on a fee for service basis for honored claims of eligible expenditures. The Board agrees to follow requirements established by ODMH for submitting claims for reimbursement through the Multi Agency Community Services Information System (MACSIS). Such requirements include provisions that CMH agencies submit claims for reimbursement using the Electronic HCFA 1500 as required by MACSIS guidelines. Reimbursement will be made at the appropriate Federal Financial Participation (FFP) of the billed amount. The Board shall make payment in full for Medicaid claims submitted for FFP reimbursement and the Board assures that payment shall be made in full for all submitted claims. The sole exception to this requirement is governmental entities as referenced in Term No. 14 of this Agreement. Reimbursement of claims for recipients eligible for Children's Health Insurance Programs (CHIP) will be reimbursed at the appropriate FFP for that program. The projected annual amount of reimbursed Purchased Services under this Board Agreement shall be the sum of total Medicaid costs identified in the attached Exhibit Bs plus any amount paid to out-of-county CMH agencies pursuant to Term No. 3.

10. The Board may modify the projected amount referenced in Term No. 9 by submitting revised Exhibit Bs and B(2)s at any time during the period of this Agreement. Rates identified in a revised Exhibit B(2) shall be effective only upon approval by ODMH.

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